Editorial

Is it about winning or losing? It's all in the eye of the beholder

By Sharon Vallone, DC, DICCP, FICCP

As we all know, we are taught from an early age that there are winners and losers in every situation. Those of us in clinical practice might have that feeling when it comes to dealing with managed care, and those in research, each time we write a grant or race for the gold (publishing) with our data. But how does this apply to our young patients? When are they winners and when are they losers?

Children are winners when they receive the support they need to be their healthiest selves. They are losers when we neglect to educate ourselves and give them the best care possible. They are losers when professional egos cannot agree and muddy the waters as parents seek information that will guide them in making the best choices for their children. They are losers when critical scientific findings are obscured or denied to further the interest of corporate advancement. They are losers when their parents are told that chiropractic care is not appropriate, or dangerous, or quackery. They are losers when we don't eloquently articulate the clinical benefits of chiropractic care for children.

As an example, in the breastfeeding world as related by Miller and Miller in their cross sectional survey of the incidence of ankyloglossia in an infant population presented with suboptimal feeding published in this issue, the release of tethered oral tissues has been on the rise over the last decade. There are differing viewpoints in all the fields associated with this diagnosis including lactation consultants, medical physicians, dentists, oral surgeons, chiropractors, osteopaths, "other bodyworkers", speech and language pathologists, and on and on. The existence of a tongue tie or any extra tissue in the oral cavity that tethers the tongue or lip or cheek are real — they would have been called "a limitation of matter" by our chiropractic forebears. BUT… before intervening with surgery, functional testing and reduction of any other interfering factors that could limit oral motor function should be addressed and function reassessed. If function has normalized and the infant can sustain normal function, surgery is not indicated. This is no different than adjusting a preteen with scoliosis and restoring normal function and alignment, thus altering the perceived necessity to perform surgery and insert Harrington Rods to support their spinal alignment.

The protocol I propose which I think would be most efficacious, would be to see a chiropractor with postgraduate training in pediatrics and specifically in oral motor dysfunction, before a release of the tissue is scheduled. An alternative for many chiropractors who see children would be to work closely with lactation consultants or speech therapists who can provide that functional assessment of the tongue in conjunction with their chiropractic evaluation. The chiropractor, in collaboration with a (breast)feeding specialist, would perform a functional assessment of the tongue (lip, cheek) and rule out biomechanical reasons why the function may be aberrant or diminished. The causes could range from upper cervical subluxation or cranial subluxation which could influence the range of motion of the temporomandibular joints to fixation of the hyoid which could influence tongue range of motion (therefore function). Even misaligned clavicle when the presentation was a shoulder dystocia, for example, could be the cause of an infant's discomfort at breast causing tension in the anterior muscles of the neck as they flex to prevent traction on the clavicle while at breast and interfering with their ability to nurse effectively. Any of these issues could arise from in utero constraint or the birth process itself, but often they will also accompany the compensations that result from a posterior tongue tie, a lip tie or even buccal ties. As practitioners we must be discerning and thorough in our examination and diagnosis.

After a thorough functional examination, if a true tethering is identified that is influencing oral motor function, then surgery is an appropriate referral to make. If the diagnosis is equivocal, a conservative management approach would be appropriate before referring for surgery. But the importance of providing the manual therapy before the surgery cannot be emphasized enough. It is still important to reduce any biomechanical restrictions and optimize gape, cervical elongation and extension so the surgeon can have a better field of vision to detect the restrictive tissue and cut it or remove it by laser. The follow up with manual therapy is to reduce compensatory biomechanical problems and support "abilitation" (Tow) of the infant to nurse properly along with the support of their lactation consultant or midwife as the surgeons or dentists do not address this and there is a high failure rate post frenotomy when there is no support for the mother. Chiropractors have a very important role on the "team" working towards the success of the breastfeeding dyad. If we claim our role, there will be more "winners" and fewer "losers."

Our authors are winners! They are working in the field or in the community of fine educators and researchers. They are writing about what they see in clinical practice, a snapshot in time of a child — evaluating them, diagnosing the root of the problem and devising a treatment protocol. Or they are documenting the data they've collected on larger scales to attempt to offer comparative results when chiropractic care is the appropriate choice for the diagnosed problem. They give us our voice. They give us the tools we need to support what we do. And for this, I am grateful.